STATE OF WISCONSIN
Department of Employee Trust Funds
Robert J. Conlin
SECRETARY

Wisconsin Department
of Employee Trust Funds
PO Box 7931
Madison WI 53707-7931
1-877-533-5020 (toll free)
Fax 608-267-4549
etf.wi.gov

Correspondence Memorandum

Date: April 17, 2020

To: Group Insurance Board

From: Liz Doss-Anderson, Ombudsperson
Mary Richardson, Ombudsperson
Dan Hayes, Attorney/Supervisor
Office of Legal Services

Subject: 2019 Health Plan and Pharmacy Benefit Manager (PBM) Grievance and External Review Report

This memo is for informational purposes only. No Board action is required.

The information provided in this report is used to identify trends and areas of concern within the health insurance, pharmacy benefit and Uniform Dental Benefit programs administered by the Department of Employee Trust Funds (ETF). A summary of this information will also be included in the 2020 *It's Your Choice* online materials.

2019 Health Plan Grievances
Below is a summary of the annual grievance data reported to ETF by all plans participating in the State of Wisconsin Group Health Insurance Program. This report also includes grievance data for Navitus Health Solutions (Navitus), the pharmacy benefits manager, and Delta Dental, third-party administrator for Uniform Dental Benefits. When reviewing the numbers of plan grievances and independent reviews that appear later in the report, it is beneficial to keep in mind that in 2019 there were approximately 236,000 members and dependents insured by the State of Wisconsin Group Health Insurance Program.

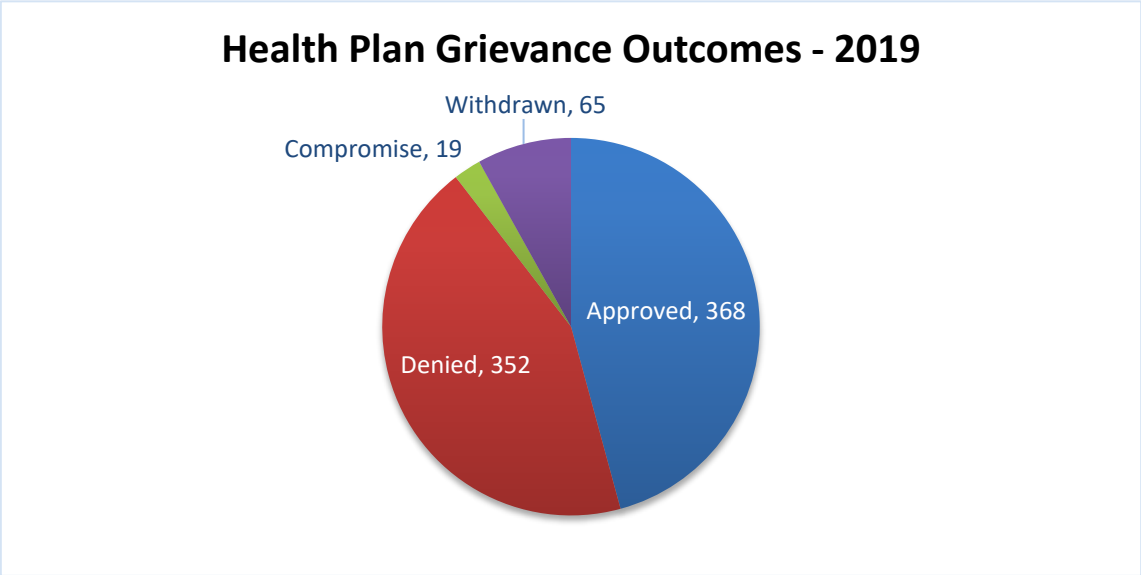
- The total number of health plan grievances reported in 2019 was 804, up from 746 in 2018, an increase of 8%.
- As in prior years, the most common types of grievances are related to:
  - Denials of coverage for services considered not medically necessary (264)
  - Non-covered benefits (97)
  - Out-of-network services and prior authorizations (90 each)

  These statistics do not include Medicare Advantage plan grievances because UHC follows CMS guidelines for reporting that do not align with our grievance categories.

Reviewed and approved by David Nispel, General Counsel, Legal Services
David H. Nispel Electronically Signed 4/29/20

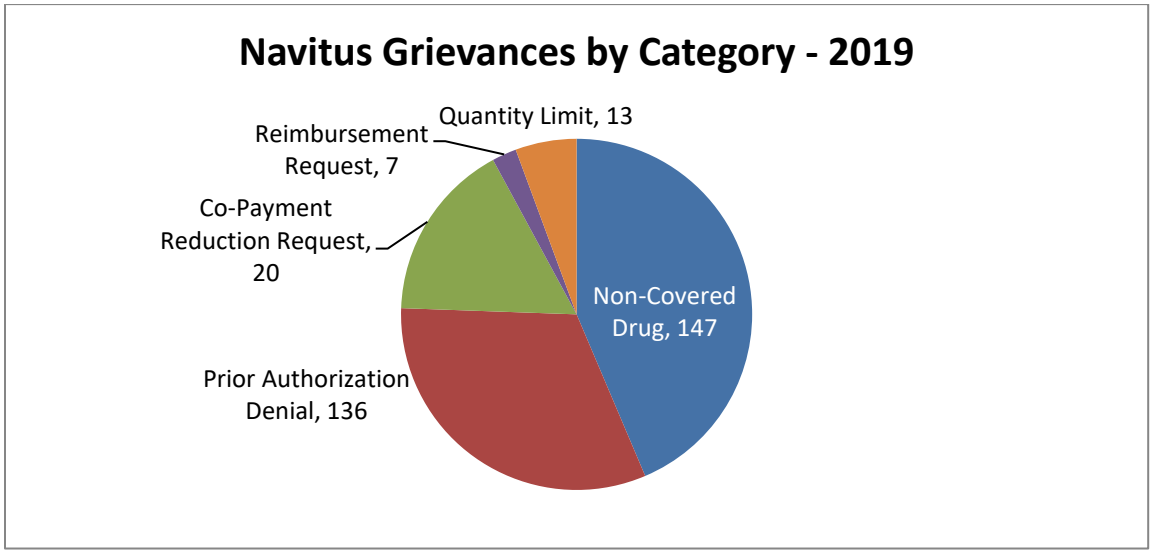
Board	Mtg Date	Item #
GIB	5.13.20	9L

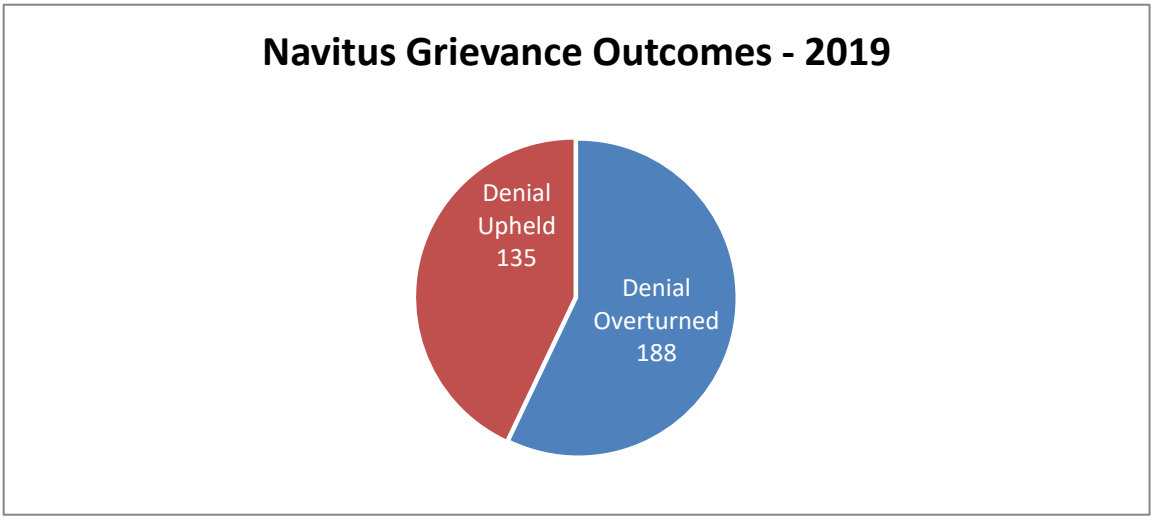
- Of the 804 grievances filed, 387 were either resolved in favor of the member or resulted in a compromise, a 48% overturn rate. This is a slightly higher rate than in the past several years when the overturn rate has been closer to 42%.
- Delta Dental had 6 grievances and served 200,600 members. The most common type of dental grievance related to a non-covered benefit.



2019 Pharmacy Benefit Grievances

- In 2019, Navitus received 323 grievances, a decrease of 60 from 383 filed in 2018.
- Consistent with prior years, the most common type of pharmacy benefit grievance was for Non-Covered Drug (147), followed by Prior-Authorization Denial (136) and Co-payment Reduction (20).
- The overturn rate for pharmacy benefit grievances continues to increase and was 58% in 2019, up from 57% in 2018 and 51% in 2017.
- Factors affecting pharmacy benefit grievances included change in the formulary, members interested in non-covered/non-formulary drugs, and requests for experimental or non-medically necessary drugs.





2019 External Reviews

This section of the report provides a summary of external review requests by State of Wisconsin Group Health Insurance program members. Members who request external reviews must have completed the health plan grievance process. External reviews are conducted by an independent review organization (IRO) that is independent of both ETF and the individual health plans.

To be eligible for external review, a member must receive an “adverse determination” involving a medical judgment. Such medically based determinations are only eligible for external review and may not be appealed to the Board pursuant to contract. Typically, these are denials of a claim or service the health plan or PBM has deemed not medically necessary or experimental. This includes denials for referral to out-of-network

services when a member believes an out-of-network provider may be medically necessary for treatment of the member's medical condition because the expertise is not available through the insurer's provider network.

The external review process allows members to have an outside medical expert review their grievance and determine if benefits are payable. The IRO's decision is binding on both the plan and the member. Thus, once an IRO decision has been made, the member no longer has a right to an administrative review through ETF or further appeal to the courts. When ETF processes a new health insurance complaint, an ombudsperson reviews it and, if appropriate, contacts the member to educate them about the external review option and process.

In 2019 the Department was informed of 94 external review requests from members, which is higher than in prior years. This is due in part to the process Medicare Advantage Plans must follow for Centers for Medicare & Medicaid Services (CMS) compliance by sending all denied appeals, including those based on medical judgement, to an Independent Review Entity contracted by CMS. The independent review organization overturned the plan decision in 30 cases, upheld the plan decision in 55 cases, and there was one compromise. There were eight cases in which the IRO declined to review the member's request as not eligible for review.

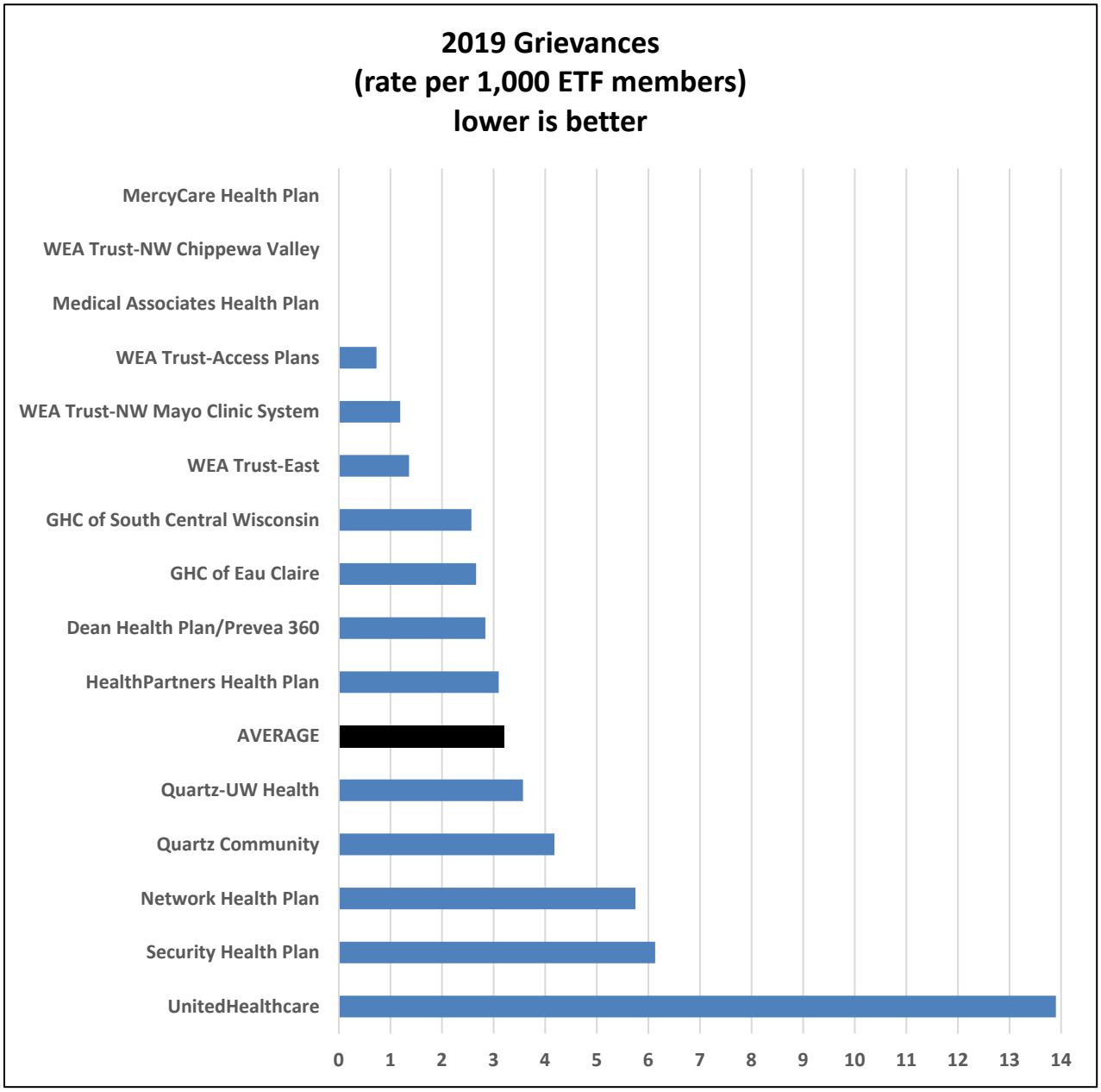
Two new initiatives in Ombudsperson Services were both health plan communication related. ETF requested that health plans submit sample grievance denial letters to ombudsperson staff that they use to inform our members of the options available for further review or assistance. After reviewing their submissions and consulting with OSHP, staff provided updated language, which was sent to all the plans for implementation. The second initiative involved a reminder to all plans regarding the required submission of notifications to Ombudsperson Services staff of requests for external review and the outcome after the review is complete.

Staff will be available at the Board meeting to answer any questions.

Attachment A: 2019 Complaints Chart
Attachment B: Grievances by Health Plan 2017-2019 Chart

Attachment A

2019 Complaints Chart



Attachment B

Grievances by Health Plan
2017-2019

HEALTH PLAN	2017 Grievances	2018 Grievances	2019 Grievances	Net Change (2018-2019)	Number of Members (2019)
Dean Health Plan/Prevea 360	115	110	129	+19	45,382
GHC of Eau Claire	3	13	3	-10	1,126
GHC of South Central Wisconsin	21	13	34	+21	13,247
Gundersen Health Plan	22	**	**	**	0
HealthPartners Health Plan	17	25	15	-10	4,825
Medical Associates Health Plan	3	3	0	-3	2,787
MercyCare Health Plan	5	4	0	-4	1,364
Network Health Plan	59	130	117	-13	20,357
Physicians Plus	31	3	**	**	0
Quartz-Community	79	90	62	-28	14,850
Quartz-UW Health	177	233	235	+2	65,836
Security Health Plan	60	49	61	+12	9,952
UnitedHealthcare	**	**	91	*	6,543
WEA Trust-East	38	50	41	-9	30,089
WEA Trust-NW Mayo Clinic System	20	14	9	-5	7,553
WEA Trust-NW Chippewa Valley	5	5	0	-5	2,647
WEA Trust-Access Plans	N/A	4	7	+3	9,530
TOTAL	**655**	**746**	**804**	**+58**	**236,088**

*** Plan not required to report grievance numbers where indicated.*

**Net change listed only for plans reporting in 2018.*